MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Pharmacy

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Contents

Medicare Part D Coverage Clarification

A table clarifying Medicare Part D coverage for specific products, drugs and drug categories in accordance with statutory and regulatory requirements has been added to the Medi-Cal Web site (**www.medi-cal.ca.gov**). To view the table, click the "Medicare Part D" link in the "What's New" area, then click the "Medicare Part D Included/Excluded Drugs - CMS Clarifications" link.

The table addresses products, drugs and drug categories that are the subject of frequently asked questions, and is not intended to be an exhaustive list. Specific products not identified in this table should always be evaluated against the statutory and regulatory definition of a "Part D drug" before drawing conclusions from the table. The table does not address Part B versus Part D coverage questions.

Negative Pressure Wound Therapy Electrical Pump Rate Change

Effective for dates of service on or after April 1, 2006, reimbursement for the rental of Negative Pressure Wound Therapy (NPWT) electrical pumps (HCPCS code E2402) is changed from a monthly to a daily rate. The new daily rate is $45.77. NPWT items require prior authorization. *This information is reflected on manual replacement page dura cd 24 (Part 2).*

Reciprocating Gait Orthoses Documentation Requirements

Providers are reminded that Reciprocating Gait Orthoses (RGOs) are reimbursable as a Medi-Cal benefit when billed with prior authorization and proof that they are medically necessary for recipients 2 years of age and older with the following conditions:

- Thoracic or upper lumbar spine lesions with spasticity;
- Contractures of all levels of the lower extremity(ies) as long as the joint(s) is (are) flexible to manipulation.

Orthotic devices are Medi-Cal benefits when the equipment is reasonable and necessary for the treatment of an illness or injury, or to improve the function of a malformed body member. Orthoses must meet all applicable Medi-Cal statutory requirements as set forth in *California Code of Regulations* (CCR), Title 22, Sections 51321 and 51521.

Please see **Orthoses**, *page 2*

Orthoses *(continued)*

The following documentation must be included when submitting a *Treatment Authorization Request* (TAR) for RGOs (HCPCS codes L2010, L2020, L2035 – L2037, L2039, L2510, L2520, L2525, L2627 and L2628):

- A primary physician must document that the recipient has cardiopulmonary integrity.
- An orthopedist or Physical Medicine and Rehabilitation Physician (PMR) must document that no other orthoses would be helpful.
- A neurologist must document that the spinal cord injury level is above L3.
- An independent physical therapist, other than the one in the orthotic/rehab unit, must document that the recipient does not have contractures and/or muscle atrophy that would preclude use of the RGO.
- X-rays of the spine must document that there is stability of the spine.
- X-rays of the spine, hips and knees must document a lack of advanced osteoporosis and fractures.
- One of the following ICD-9 diagnosis codes must be included on the TAR:
  - 344.1 (paraplegia);
  - 741.92 (spina bifida, without mention of hydrocephalus, dorsal [thoracic] region); or
  - 741.93 (spina bifida, without mention of hydrocephalus, lumbar region)

In addition to the above documentation, the following documentation is required when a TAR for RGOs is submitted for recipients 21 years of age and older:

- Plantigrade feet
- Knees and hips must not have greater than 10 degrees of contracture
- The hips must be flexible without rigidity or spasticity
- Good upper extremity strength
- Motivated, has realistic goals and expectations, and has a support system

Contraindications to RGOs include the following:

- Severe irreducible contractures that prevent establishing normal alignment
- Spasticity or other voluntary muscle activity that prevents free and coordinated mobility
- Obesity (BMI > 32)
- Poor upper extremity strength
- Advanced osteoporosis
- Fractures or a history of fractures
- History of not following treatment plans (noncompliance)
- Pressure sores in areas that would be in contact with the orthosis

The treating therapist and/or orthotist must submit a report to the primary care physician at six months of use to document the recipient's success or failure with the RGO.

The updated information is reflected on manual replacement page ortho 12 (Part 2).

Therapeutic Diabetic Shoes and Inserts: New Benefit

Effective for dates of service on or after April 1, 2006, therapeutic diabetic shoes and inserts are a new benefit for recipients with a diagnosis of diabetes mellitus. HCPCS codes for the new benefits are as follows:

HCPCS Code	Description
A5500	Fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe
A5501	Fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe
A5503	Modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe
A5504	Modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe
A5505	Modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe
A5506	Modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe
A5507	Not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe
A5512	Multiple density insert, direct formed, molded to foot after external heat source of 230 degree Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each
A5513	Multi-density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each

Prior Authorization
These services require prior authorization. With the *Treatment Authorization Request* (TAR), providers must submit a clinician-signed *Clinician Certification of Medical Necessity for Therapeutic Shoes* form to certify that the recipient has one or more of the following conditions:

- Foot ulcers
- Previous amputation of the contralateral foot, or part of either foot due to microvascular disease secondary to diabetes
- History of previous foot ulceration of either foot
- Peripheral neuropathy with evidence of callous formation of either foot
- Foot deformity of either foot, that is, rocker bottom foot or Charcot foot
- Documentation of compromised vascular disease in either foot
- Positive monofilament examination indicating diabetic neuropathy

The *Clinician Certification of Medical Necessity for Therapeutic Shoes* form has been developed and is included in this bulletin to help providers meet prior authorization documentation requirements.

The following additional information is required on the *Clinician Certification of Medical Necessity for Therapeutic Shoes* form, as appropriate, for prior authorization of codes A5501 and A5513:

- Diabetes mellitus with neurological manifestations
- Diabetes mellitus with peripheral circulatory disorders
- Diabetes mellitus with other specified disorders (amputations, significant deformities and or pre-ulceration)

Please see **Therapeutic Shoes**, *page 4*

Therapeutic Shoes *(continued)*

Billing Instructions/Limitations
Only orthotists and prosthetists may bill for these services. Claims for orthotic and prosthetic appliances require modifier -LT (left side) and/or -RT (right side), as appropriate.

Codes A5500 and A5501 have a frequency restriction of one pair per calendar year. Codes A5512 and A5513 are restricted to three pairs per calendar year when billed in conjunction with either code A5500 or A5501.

This information is reflected on manual replacement pages ortho 11 (Part 2), the new Clinician Certification of Medical Necessity for Therapeutic Shoes form (Part 2) and ortho cd1 1 (Part 2).

Pharmacy Minimum and Maximum Quantity Limits for Ortho Evra Patch

Effective retroactively for dates of service on or after March 24, 2005, the dispensing of Ortho Evra Patch contraceptives in pharmacies is limited to a minimum of one and a maximum of nine patches per recipient by any provider within a 90-day period. The billing of ten or more patches exceeds the 100-day supply restriction. Clinic dispensing of Ortho Evra Patch contraceptives (HCPCS code X7728) remains unchanged.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Provider Orientation and Update Session

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The remaining date for the first quarter of 2006 is listed below.

Group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client-education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Session below.

March 20, 2006
California Department of
Health Services Auditorium
1500 Capitol Avenue
Sacramento, CA 95814

For a map and directions to the CDHS Auditorium, go to the Family PACT Web site at **www.familypact.org** and click "map" under "Orientation Sessions."

Please see **Family PACT**, *page 5*

Family PACT *(continued)*

Registration
To register for an Orientation and Update Session, go to the Family PACT Web site at **www.familypact.org** and click the appropriate date under "Orientation Sessions" and print a copy of the registration form. Fill out the form and fax it to the Office of Family Planning at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider is mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information
For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	*Contents for Pharmacy Billing and Policy* v/vi *
Remove and replace:	dura cd 9/10 *, 23/24
Remove:	ortho 11/12
Insert:	ortho 11 thru 15
Insert after the end of the *Orthotic and Prosthetic Appliances* section:	*Clinician Certification of Medical Necessity for Therapeutic Shoes* form
Remove:	ortho cd1 1 thru 26
Insert:	ortho cd1 1 thru 31

* Pages updated due to ongoing provider manual revisions.